Today’s Agenda
Topic: ITU and Critical Care

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<th>Agenda Item</th>
<th>Duration</th>
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<td>Sharing experience and learning working within ITU at Southampton General Hospital</td>
<td>Dr Carol Davis</td>
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<td>Sharing experience and learning working within ITU at the Brompton Hospital</td>
<td>Dr Ros Taylor</td>
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<td>Discussion</td>
<td>ALL</td>
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<td>AOB</td>
<td>Anita Hayes</td>
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Sharing experience and learning working within ITU at Southampton General Hospital
Dr Carol Davis
Consultant in Palliative Medicine and Clinical End of Life Care Lead
Southampton General Hospital

“I know that I am between a rock and a hard place. I just want to do 3 things…”
- See my daughter’s ‘baby scan’
- Go home
- Die comfortably

The Size of the Problem

- ICU Mortality 15-25%
- ICU admission in the last months of life growing
- Complexity increasing
- Distressing symptom prevalence up to 75%
- Post ICU Syndrome common in relatives and carers
- Staff compassion fatigue?
Palliative Critical Care at UHS

Annual Referrals

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
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<tbody>
<tr>
<td>2013</td>
<td>50</td>
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<tr>
<td>2014</td>
<td>60</td>
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<td>2016</td>
<td>80</td>
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<td>2017</td>
<td>90</td>
</tr>
<tr>
<td>2018</td>
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“Palliative Critical Care is better...like before it hits 4:30 on Fridays afternoon!”

www.theinkvessel.com
Consequences; some anticipated, some not…..

- Cemented relationships with parent teams
- Raised profile of palliative care alongside others in complex clinical decision making
- Increased referrals from other ITUs and Respiratory High Care
- Changes in ICU prescribing
- Possible influence on peri-operative care
- Long-term involvement post GICU
  - same admission
  - subsequent admissions

3 months in to an ICU admission…..
# tricks of the trade….

- All the HPCT need to be comfortable seeing patients on ITU and interacting with senior staff
- However high your profile, you still need to work at relationships to keep referrals coming
- Time consuming – establish some boundaries

Up-skilling or down-skiling of ICU staff?

Key messages

- This QI initiative has transformed the relationship between GICU and the HPCT from one of occasional interaction to a regular programme of collaborative working
- Sustained increase in referrals since 2014
- Patient preferences have been supported
- Integrating palliative care and critical care has been a hugely positive process for staff, patients and carers
- GICU staff now feeling more confident about palliative care
- The Palliative Care Team are influencing the care of far more people than they actually see
- Our model is transferrable to other centres and clinical situations

Quotable quotes …from patients

- “Palliative care has made a much bigger difference than I could ever have imagined…can’t believe I was scared when they first mentioned it to me”

Quotable quotes …from families

- The family are really grateful that he was able to get straight to the hospice for his last few days
- It’s amazing, we had no idea you could have Palliative Care on Intensive Care, especially for someone who doesn’t have cancer and who isn’t dying.

Quotable quotes…from GICU staff

- Staff are driven and passionate in providing the best possible outcome in Palliative Situations
- The team on GICU is large and diverse with different areas where passions are able to shine; Palliative Care is one of those areas
Quotable quotes...surgeon

I got to know you best on ICU...I really trust your judgement when decision-making is tricky.

Quotable quotes...ICU ward clerk

It’s great to see Palliative Care on the ICU... What I’ve noticed is that you make a difference not only to patients and their families, but a massive difference to the staff too – it’s really tough for them up here.

Palliative care and the ICU

Advanced hand-holding or a meaningful role....

Dr Ros Taylor
Locum Consultant Palliative Medicine

Numbers....
How many deaths?
How many discharges?
How many leave hospital?

Advance Care Planning

• Not just about DNACPR and place of death

Advance Care Planning

• Help patients and their families prepare for the last stage of life, review their immediate goals and hopes
• Think about and document wishes for treatment/setting
• Think about what is NOT wanted
DEATH ANXIETY

The feeling of fear, dread, apprehension when one thinks about the process of dying or ceasing to exist...

G Farley 2013

Death anxiety in NYC after 9/11

Key finding: interpersonal communication is an important means of reducing existential terror


How people die remains in the memory of those who live on....

Dame Cicely Saunders

event-centred care?

• Treat each event as a discrete reversible episode without taking into account:

RESCUE
Communication and hope in ICU

The healing power of listening in the ICU
Valuing what family tell you
Acknowledging their emotions
Listening very carefully for cues
Understanding who the person is
Elicit questions

Lilly CM et al.

Letting go: family willingness to give up life support
1. Relinquish the goal of recovery
2. Life review and sense of meaning re: patient wishes
3. Doing the ‘right thing’

Swigart et al.

Dealing with conflict in caring for the seriously ill….a GREAT PAPER!
Doctor: Family
Doctor: Nurse
Family: Family
Step-wise approach & communication tools

Back AL, Arnold RM
JAMA 2005 293(11):1374-81

Approaching patients and family members who hope for a miracle
79% believed in miracles……
Use the VALUE model and offer spiritual support

Widera EW et al

Wish
Worry
Wonder
"Yes it's sad, but what should I do?"
Moving from empathy to action in discussing goals of care

Emotional mind + Rational mind = Wise mind

Back AL et al.
J Palliat Med 2014 17(2):141-4

What does good end of life care in the ICU look like?

Factors associated with family satisfaction with end-of-life care in the ICU: a systematic review

Good-quality communication,
Support for shared decision-making,
Specific patient-care measures

Hinkle L J et al.
Chest 2015 147(1):82-93

In their own words: patients and families define high-quality palliative care in the intensive care unit

• timely, clear & compassionate communication
• clinical decision-making focused on patients' preferences, goals, and values
• maintaining comfort, dignity & personhood
• family care with open access
• bereavement care for families


Goals of Care

• COMFORT
• Alleviate pain and dyspnoea
• Control bleeding with minimal interventions
• Control seizures

• Minimise anxieties for patient (if conscious) and family
• Support family and patient spiritually and psychologically
• Dichotomy between treating patients versus treating family in ICU (Pattison et al 2013)

Symptomatology

<table>
<thead>
<tr>
<th>Symptom</th>
<th>m</th>
<th>s</th>
<th>95% CI</th>
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<tbody>
<tr>
<td>Pain</td>
<td>90</td>
<td>66</td>
<td>66.5-92.3</td>
</tr>
<tr>
<td>Anxiety</td>
<td>69</td>
<td>31</td>
<td>31.3-79.3</td>
</tr>
<tr>
<td>Fatigue</td>
<td>64</td>
<td>36</td>
<td>36.1-76.5</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>41</td>
<td>21</td>
<td>21.4-70.9</td>
</tr>
<tr>
<td>Paralysis</td>
<td>41</td>
<td>21</td>
<td>21.4-69.9</td>
</tr>
<tr>
<td>Constipation</td>
<td>32</td>
<td>19</td>
<td>19.1-51.3</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>64</td>
<td>36</td>
<td>36.5-88.3</td>
</tr>
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Puntik K et al 2010 Crit Care Med. 38(11):2155-60
Douglas M 59 yo

• Background: smoker for years
• Children: 8 yo M, 14 yo F
• 24/1 R pneumonectomy @RBH
• 17/02: BP fistula
• 18/02 Rigid bronch+VATS washout
• 1/3 Discharged home
• 8/04 Presented to Essex Hosp
• With fever and malaise

• Started on pip/taz
• 20/04 Acute SOB→intubation→hypoxemic PEA arrest→7 cycles CPR (downtime 20 min)
• After ROSC ...... referral to RBH
• In AICU:
  — Resp Failure: resolved
  — AKI: resolved
  — NEURO:

• CT: normal
• EEG: in keeping with diffuse brain injury
• MRI: catastrophic brain injury
• Neuro consultation: poor prognosis

• Family discussion
• Non-recoverable brain damage
• Goal of care....
• Decision to palliate

Context

• Intubated and ventilated
• No cardiovascular support
• Good urine output
• Nasogastric fed
• Normal labs
‘In hospital, you can only die when medical staff declare you can die....’

Bostanci 2015

How would you withdraw life sustaining treatment?

...what we did...

- On Oramorph to treat pain and distress
- Patient is extubated
- Maintains own airway
- Nutrition/hydration maintained
- Died 2 weeks after (transferred for EoL Care)

Withdrawal of life support
- Withdrawal is not euthanasia
- Underlying processes are what causes a patient to die (George, 2007) .... although often debated

NB advance care planning before high risk procedures!

Preparation for withdrawal
- Preparation for Withdrawal and EOLC need to be simultaneous:
- Family: encourage presence, therapeutic touch
- Understanding patient preferences
- Ignore visiting rules!!
- Stop tests etc...
- Counsel family as to what will/likely to happen
- Think timing:
  - ICU specialists can predict death within 60 minutes, 50% of the time (Bronow et al CCM 2013 41(12):0077)
Preparation cont....

- Ensure clear lines of communication
- Facilitate MDT/families to contribute
- Involvement of palliative care team
- Offer rationale to colleagues for decisions
- In tricky situations: clinical ethics committee

Managing Uncertainty

- Evans (2009):
  - 87% of relatives wanted physicians to discuss an uncertain prognosis:
    - Uncertainty is unavoidable
    - Leaves room for realistic hope
    - Increases trust in the clinician
    - Signals a need to prepare for possible bereavement

Impact on HCPs

- Treatments in face of futility are distressing for those witnessing it and those providing care - burnout (Piers R et al JAMA 2014)

A hesitation to be brave....

Dr Kieran Sweeney
Our next ECHO session…

**Date:** 13 March 2019

**Topic:** Sustainability COP where next

[https://www.youtube.com/watch?v=gN--7WFOlx8](https://www.youtube.com/watch?v=gN--7WFOlx8)